

My name is Dr. Leon Assael, Dean of the University of Minnesota School of Dentistry. I am here to speak in support of the concept of dental therapy practice in North Dakota.

We now have a half decade experience with dental therapy in Minnesota and I offer a brief update on our progress in education and practice. I will focus on education, public need.

EDUCATION: Dental therapy is not a new profession. Dental therapists have consistently practiced in the United Kingdom for nearly 50 years and in New Zealand for 90 years. Dental therapy is well established in more than 50 countries, including those with advanced care systems similar to those in the U.S. It is *so well established* that there exist comprehensive program accreditation processes that are similar to that of the U.S. Standards used by the Dental Councils of Australia and New Zealand include all of the same categories for their dental therapy programs as do our own Minnesota accreditation standards. These include standards on admission policies and procedures, curriculum, clinic, administration, preparation for practice, student assessment and examination, evaluation procedures and outcomes, research, and articulation pathways (team integration experience). In the UK, the General Dental Council regulates all dental professionals (including dental therapists) in England, Wales, Scotland and Northern Ireland...and there are processes in-place since 1997 to check whether dental therapy programs meet their training requirements, including inspections similar to our accreditation site visits for all new programs, and an annual monitoring system which can precipitate additional inspections of a program suspected of not meeting the requirements.

To this documentation of international longevity, I add the experience of the University of Minnesota, School of Dentistry. Now in its fifth year, our dental therapy program has exceeded expectations. We have graduated 18 dental therapists, will graduate our third class of 9 students in December, we have 15 students in the education pipeline, and applicant interest remains high. Our students come to us with high academic credentials and motivated to be essential health care providers for underserved communities and to enhance oral health in those settings through community engagement. In addition the Minnesota State Colleges and Universities system sponsors a program at Metropolitan State University.

Accepted benchmarks and performance measures are already in-place in Minnesota. The procedures dental therapists are qualified to perform are not *unique* to dental therapy education. In the United States, all dental procedures – including those in the scope of practice for dental therapists – are taught as part of an accredited dental or dental hygiene education program. Again, I offer the example of the dental therapy program at the University of Minnesota. We are a CODA-accredited dental and dental hygiene program. Dental therapy students are fully integrated into existing dental and dental hygiene education classes, and learn in the same facilities, from the same faculty and using a subset of the same curriculums. Indeed for the courses that are relevant to dental therapy practice, much of the coursework is side by side with DDS students. This continues in the clinical education setting. Our program is accredited under the aegis of the Board of Dentistry of Minnesota.

PUBLIC NEED: There are two high profile...and very public initiatives...that demonstrate the need for dental therapy. The first is the 2000 report from the United States Surgeon General titled *Oral Health in America* which documents in a most public...profound...and consequential way...the *need* to address deficiencies in access to dental care in the United States. The second is the national debate about healthcare reform...and the *need to enhance access to 'affordable' health care*.

The Surgeon General's report prompted public concern and attention by federal and state legislators, professional organizations and media that has led to increased efforts to reduce and eliminate oral health disparities between those well served and those poorly served. One of the several strategies proposed includes the education and deployment of new allied health care providers such as dental therapists. This approach is seen as a way to help expand the workforce and enhance the capacity of current providers to treat more patients by allowing dentists to practice at the top of their license, while delegating less complex procedures to a dental therapist. Increasingly, legislators – in Minnesota, Ohio, Maine, N.H., Vermont, Kansas, New Mexico, Washington and others – have recently considered or are currently considering dental therapy or midlevel provider legislation. Addressing access to care issues was the most prominent objective in decisions made to authorize dental therapists in remote areas of Alaska and in the state of Minnesota. And while we all know there is no one way to solve access challenges in this country, dental therapy is increasingly viewed as one way to address the unmet need for oral health care services. It is also hoped that a shorter educational time commitment for dental therapists and lower tuition costs may provide opportunities to contain the cost of health care. Whatever else might be said here today, there can be little disagreement that ...nation-wide... there is a compelling need for enhanced 'access to oral health care' and access to 'affordable' health care.

Dental therapy is not only good for the public, it is good for the practice of dentistry and for dentists who employ dental therapists. Dentists are unwilling and unable to care for patients with high disease rates often because of the low reimbursement rate or in the case of many children and elderly with patient management barriers such as extensive office visit time that make the cost of care too high to justify taking on those patients. Dental therapists like dental hygienists can offer the dentist the opportunity to care for those patients while also practicing those more complex procedures. Thus the child who needs 30 minutes of coaxing, or the elderly patient who requires frequent breaks, or the high caries rate Medicaid patient become those who can be accepted by the dentist, increase overhead at only the marginal cost, thus reduce the unit cost of treatment; and allow the dentist to expand access into their practice. In that fashion, the dental therapist, side by side with the dentist, can impact disease treatment for greater numbers at lower per unit cost.

PUBLIC SUPPORT: When it comes to interest in and support for dental therapy in specific, significant interest on the part of state legislatures, as well as support from various public interest Foundations such as PEW and Kellogg, the Association of Public Health Dentistry and the American Dental Hygiene Association is ongoing. Several state coalition groups are supportive -- the Kansas Action for Children, Health Action New Mexico, University Health Care Action Network in Ohio, Voices for Vermont's Children, Children's Alliance in Washington – among them. The Safety Net Coalition in Minnesota is a strong advocate for dental therapy and was instrumental in advancing legislation.

The Federal Centers for Medicare and Medicaid demonstrated their interest, as well and, this year, awarded a \$45 million State Innovation Model (SIM) grant to the Minnesota Department of Health and the Minnesota Department of Human Services. These two major public agencies purposely included dental therapists in their innovation models with the stated goal to...quote...**“Expand the use of non-MD... innovative provider types (e.g. community health workers, community paramedics, dental therapists)... within primary care practices.”** The approach is consistent with the move into a healthcare environment in which care is provided by interdisciplinary teams and coordinated across settings that will prompt new skills and new provider types to come to the fore. The national grant is to work in support of the integration of new providers such as dental therapists into clinical practices.

Additional external public and professional support comes with more funding from such entities as the Minnesota Department of Health, the Otto Bremer Foundation, and the Delta Dental Foundation (RFP to be released in November) who have also invested in tools and resources related to the sustainability of the dental therapy profession. Numerous community stakeholder groups weighted with letters of support.

There is **support**, too, from employers. Minnesota's dental therapists are employed.... in private practice...in group practices...in non-profit community clinics and in FQHCs. They are employed in both urban and rural areas. Some also teach. And the feedback from these 'early adopter' employers has all been positive. A recent University of Minnesota survey -- which is part of our dental school's robust research initiative to evaluate attitudes related to acceptance, attitudes, performance and employability of our dental therapy students (19 - 23) -- points to an even more promising future. The random-sample survey of 1,000 dentists generated a 55% response rate. More than one third of respondents reported positive attitudes toward the dental therapy model and perceive the dental therapist as a viable solution to addressing dental need in the state. The manuscript of these findings will be completed shortly and submitted to a peer review journal for publication. The State of Minnesota and its land-grant University also support the new dental therapy programs and there is no reason to expect that this support will change.

Finally, the profession, too, is moving forward. Dental therapy was a significant part of the professional programs at the American Dental Education Association's mid-year meetings (for academic deans, student affairs and student groups); at the deans' meeting and at the annual ASDA and ADEA meetings. White papers and discussions are part of the American Academy of Pediatric Dentistry meetings. The American Dental Education Association (ADEA) developed and approved a policy statement entitled "ADEA Guiding Principles for the Education of Oral Health Professionals in Emerging Workforce Models ." The purpose of this document is to maintain high standards for the education preparation of dental professionals in these emerging models. Now the Commission on Dental Accreditation, the body under the US department of education that accredits dental programs, has developed accreditation standards for public consideration on Dental Therapy education.

On a personal note, I believe that all the health professions are given a great opportunity, granted by the public through their legislatures, to serve the needs of the public. The health professions have a special privilege and a special responsibility in that regard. We have worked hard to improve oral health care and oral health outcomes but we have made scarce progress for the population as a whole. Beyond the great benefits of fluoridation and wonderful technologic progresss, there is a sea of untreated disease that disproportionately affects the very young, the very old, the poor and those with medical co-morbidities. To address these patients needs we must access them beyond the dental office, we must provide high quality care at a reduced unit cost for that care. We must keep the dentist at the head of a robust and expanding oral health care team to accomplish that goal. Dental therapy is a profession that will improve the health of patients and the wellbeing of our society.